Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 4, 2015	2015_346133_0017	O-001540-15	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

MONTFORT
705 Montreal Road OTTAWA ON K1K 0M9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 19th - 22nd, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Environmental Manager, the Director of Care, dietary services staff, maintenance service staff, and residents.

The inspector tested and verified the operations of the elevators with a focus on the possibility of resident access to the basement via the elevators. In the basement, the inspector observed the service areas and doors leading to stairways and to the outside of the home.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 10. (1)	CO #002	2014_286547_0032	133

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1 in that the licensee has failed to ensure that the basement level doors that lead to the outside of the home, and the basement level door that leads to a stairway, are kept closed and locked; equipped with a door access control system that is kept on at all times; and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident – staff communication and response system, or is connected to an audio-visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. These doors are accessible to residents as a result of elevator #1, considered to be the service elevator.

This will be the licensee's second consecutive finding of non-compliance related to the basement doors that results in the issuance of a Compliance Order. The first compliance order was issued on January 21st, 2015, as a result of the Resident Quality Inspection (RQI #2014_286547_0032, CO #001), which was conducted in December 2014. The non-compliance presented below presents an ongoing potential risk to residents who use the home's elevators independently.

The home's basement is a service area and is not an area to be accessed by residents. The basement contains areas such as the main kitchen, the laundry room, the staff room, the environmental manager's office, maintenance work spaces, and equipment rooms.

In the basement, in the immediate area of the elevators, to the left, there is a door that leads to a stairway (door # C0). To the right of the elevators, and around a small corner, there is a set of double doors that lead to the outside of the home, to the shipping and receiving area. Next to the shipping and receiving doors, to the right, there is a single door that leads to the outside of the home, which is mainly used as a staff exit/entrance. None of these doors are locked or alarmed as required by O. Reg. 79/10, s. 9 (1) 1.

Over the course of the follow up inspection, May 19th - 22nd, 2015, inspector #133 determined that the exit doors and stairway door in the basement are potentially accessible to residents as a result of the service elevator (elevator #1).

The home has two elevators; they are side by side, are accessible to residents and go down to the basement level. If an elevator is called for by someone who is in the basement, only elevator #1 will respond to the call. Elevator #2 will not respond to a call made from the basement. This is a result of corrective actions taken by the licensee, in response to a Compliance Order issued as a result of the Resident Quality Inspection (RQI #2014_286547_0032, CO #002) related to the elevators. At that time, December 2014, if someone in the basement called for an elevator, both would descend.

The home's elevators are equipped to restrict resident access to the basement, but not to prevent it. An access swipe card is required, within the elevators, to activate the button that will send the elevator down to the basement. Only staff have the access swipe cards. Residents do not have access swipe cards and therefore cannot select the basement level once they are in the elevator. Regardless of this system in place, residents who use the elevators can be inadvertently brought down to the basement in elevator #1. This inadvertent access can occur when a staff member in the basement

calls for an elevator, by pushing the button on the wall, before a resident who is in the elevator pushes the button for the floor they wish to go to. As the staff member in the basement pushed the button first, the resident in the elevator will be brought down to the basement, and then the elevator will go to the level that was selected secondly. In this scenario, the resident in the elevator gains access to the basement without having used an access swipe card. On May 20th, 2015, at 10:30am, the inspector and the home's Environmental Manager (EM) worked together to test elevator #1 and validated that inadvertent access to the basement does depend on which button is pressed first.

It is noted that at several points during the inspection, during discussions with the Administrator and with the Environmental Manager, the inspector was told that following the Resident Quality Inspection (#2014_286547_0032), conducted in December 2014, all staff were asked to ensure that if they call for an elevator from the basement, they remain in place until the elevator arrives, in attempt to prevent residents from having unsupervised access to the basement.

The following observations and conversations support the possibility that residents may be inadvertently brought down to the basement in the elevator. As well, there is evidence to suggest that there is not always a staff member present when a resident is inadvertently brought down to the basement in the elevator.

a) On May 20th, 2015, at 10:46am, the inspector was in the basement and used an access swipe card to activate the button to call for the elevator. Elevator #1 responded to the call. When the elevators doors opened, the inspector saw that the home's Environmental Manager (EM) was in the elevator. The EM indicated to the inspector that he was surprised that the elevator had brought him down to the basement. The EM explained to the inspector that he had entered the elevator from the main floor level, and had pressed the 2R button, as he was intending to go to the 2nd floor service area.

b) On May 20th, 2015, at 10:50am, the inspector was again in the basement and used an access swipe card to activate the button to call for the elevator. Elevator #1 responded to the call. When the elevator doors opened, the inspector saw that a man and a woman were in the elevator, and they expressed confusion as to why they had been brought down to the basement. The inspector went into the elevator with them, and they introduced themselves as family of resident #001. They explained that they were at the home for a care conference for resident #001. They explained they had entered the elevator from the main floor, and had pressed the 2 button, intending to go up to the second floor.

c) On May 20th, 2015, at 11:11am, the inspector spoke to a cook, #S100, and a dietary aid, #S101, in the kitchen, in the basement. The dietary aid was preparing sandwiches at the time, standing at a work station that allows for visual access of the service elevator area. The inspector asked the staff if they have ever noticed if residents are brought down to the basement in the elevator. They indicated that there are times that residents are brought down to the basement in the elevator, by accident, because someone has called for the elevator from the basement. They specified that it does not happen frequently. Staff #S100 explained that he uses the elevator frequently to go up to the unit serveries. Staff #S100 explained that when he finds a resident in the elevator, in the basement, he makes sure the residents gets back up to the floor that they had intended to go to.

d) On May 21st, 2015, the inspector spoke with a member of resident council, resident # 002, about his/her use of the elevators. The resident confirmed that he/she uses the elevators frequently, and independently. The inspector asked the resident if the elevators had ever brought him/her down to the basement. The resident told the inspector that recently, within the last month, he/she had entered one of the elevators, on the 2nd floor, and then pressed the button to go to the main floor. The resident explained that the elevator did not stop at the main floor, rather, it brought him/her down to the basement. The resident said that it had seemed like no-one had called for the elevator, as he/she didn't see anyone when the elevator doors opened, and no-one got into the elevator with him/her. The resident explained that he/she stayed in the elevator and pressed the button to go back up, to the main floor.

Resident #002 potentially had unsupervised access to the basement at this time.

e) On May 22, 2015, the inspector spoke with resident #003. This resident's name had been provided to the inspector by a Personal Support Worker, who knew that the resident used the elevator independently and would be able to converse with the inspector about it. The inspector asked the resident if the elevator had ever brought him/her down to the basement. The resident indicated that the day before, May 21st, 2015, he/she had ended up in the basement, but he/she had assumed that they had mistakenly pressed the basement button. The resident explained he/she had entered the elevator from the second floor, and had pressed the button to go down to the main floor. The inspector explained to the resident that as the resident does not have an access swipe card, it would not have been possible for him/her to activate the basement button.

The resident said that when the elevator doors opened, he/she could see into the kitchen, and also noticed some large boxes in the hallway and some men working. The resident said that he/she knew right away that they were in the wrong place, and he/she pushed the button to go back up to the main floor. The resident indicated that no one got into the elevator with them. The inspector had been in the basement on multiple occasions on May 21st, and recalled that there had been a number of boxes, in the hallway in front of the elevator, that afternoon, as observed by resident #003.

Further exacerbating the potential risk related to resident access to the basement are the two following issues:

a) Elevator #1 can only be called to the basement with the use of an access swipe card. This is a result of corrective actions taken by the licensee, in response to a Compliance Order issued as a result of the Resident Quality Inspection (RQI #2014_286547_0032, CO #002), related to the elevators. At that time, in December 2014, any person in the basement could call for an elevator, an access swipe card was not needed. The Administrator explained to the inspector that the rational for this change was as follows: by allowing only staff in possession of an access swipe card to call for an elevator, the use of the elevator would be more controlled, and there would be a greater likelihood that a staff member would be present when the elevator descended to the basement.

Residents do not have elevator access swipe cards. If a resident was inadvertently brought down to the basement and left the elevator, the resident would not be able to independently call for the elevator to come back. If there was no staff member present, the resident would have to find another way to leave the basement. The resident-staff communication and response system is not available in the basement. The unlocked and unalarmed stairway and exit doors are all in close proximity to the elevator.

b) The basement doors that lead to the outside of the home are locked from the outside. An access swipe card is required to unlock these doors from the outside. If a resident exited the home through these doors, they would not be able to return back inside the home through these doors. The space immediately outside of the doors is a receiving area that is below grade and it leads up to the main road used to access the home and the back area of the neighboring hospital. The roadway also goes down a hill and leads to a 4 lane parkway. [s. 9. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 4th day of June, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2015_346133_0017
Log No. / Registre no:	O-001540-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 4, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	MONTFORT 705 Montreal Road, OTTAWA, ON, K1K-0M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bernard Bouchard

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_286547_0032, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that in the basement, doors that leads to a stairway and doors that lead to the outside of the home are kept closed and locked.

The licensee shall ensure that in the basement, doors that leads to a stairway and doors that lead to the outside of the home are equipped with a door access control system that is kept on at all times.

The licensee shall ensure that in the basement, doors that leads to a stairway and doors that lead to the outside of the home, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The licensee shall ensure that as required by O. Reg. 79/10, s. 9 (1) 4, all alarms for doors leading to the outside are connected to a back up power supply, unless the home is not served by a generator.

Until such time as compliance is achieved with this Compliance Order, the licensee shall immediately implement measures to ensure resident safety, related to the possibility of unsupervised access to the basement.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1 in that the licensee has failed to ensure that the basement level doors that lead to the outside of the home, and the basement level door that leads to a stairway, are kept closed and locked; equipped with a door access control system that is kept on at all times; and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident – staff communication and response system, or is connected to an audio-visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. These doors are accessible to residents as a result of elevator #1, considered to be the service elevator.

This will be the licensee's second consecutive finding of non-compliance related to the basement doors that results in the issuance of a Compliance Order. The first compliance order was issued on January 21st, 2015, as a result of the Resident Quality Inspection (RQI #2014_286547_0032, CO #001), which was conducted in December 2014. The non-compliance presented below presents

an ongoing potential risk to residents who use the home's elevators independently.

The home's basement is a service area and is not an area to be accessed by residents. The basement contains areas such as the main kitchen, the laundry room, the staff room, the environmental manager's office, maintenance work spaces, and equipment rooms.

In the basement, in the immediate area of the elevators, to the left, there is a door that leads to a stairway (door # C0). To the right of the elevators, and around a small corner, there is a set of double doors that lead to the outside of the home, to the shipping and receiving area. Next to the shipping and receiving doors, to the right, there is a single door that leads to the outside of the home, which is mainly used as a staff exit/entrance. None of these doors are locked or alarmed as required by O. Reg. 79/10, s. 9 (1) 1.

Over the course of the follow up inspection, May 19th - 22nd, 2015, inspector #133 determined that the exit doors and stairway door in the basement are potentially accessible to residents as a result of the service elevator (elevator #1).

The home has two elevators; they are side by side, are accessible to residents and go down to the basement level. If an elevator is called for by someone who is in the basement, only elevator #1 will respond to the call. Elevator #2 will not respond to a call made from the basement. This is a result of corrective actions taken by the licensee, in response to a Compliance Order issued as a result of the Resident Quality Inspection (RQI #2014_286547_0032, CO #002) related to the elevators. At that time, December 2014, if someone in the basement called for an elevator, both would descend.

The home's elevators are equipped to restrict resident access to the basement, but not to prevent it. An access swipe card is required, within the elevators, to activate the button that will send the elevator down to the basement. Only staff have the access swipe cards. Residents do not have access swipe cards and therefore cannot select the basement level once they are in the elevator. Regardless of this system in place, residents who use the elevators can be inadvertently brought down to the basement in elevator #1. This inadvertent access can occur when a staff member in the basement calls for an elevator, by pushing the button on the wall, before a resident who is in the elevator pushes

the button for the floor they wish to go to. As the staff member in the basement pushed the button first, the resident in the elevator will be brought down to the basement, and then the elevator will go to the level that was selected secondly. In this scenario, the resident in the elevator gains access to the basement without having used an access swipe card. On May 20th, 2015, at 10:30am, the inspector and the home's Environmental Manager (EM) worked together to test elevator #1 and validated that inadvertent access to the basement does depend on which button is pressed first.

It is noted that at several points during the inspection, during discussions with the Administrator and with the Environmental Manager, the inspector was told that following the Resident Quality Inspection (#2014_286547_0032), conducted in December 2014, all staff were asked to ensure that if they call for an elevator from the basement, they remain in place until the elevator arrives, in attempt to prevent residents from having unsupervised access to the basement.

The following observations and conversations support the possibility that residents may be inadvertently brought down to the basement in the elevator. As well, there is evidence to suggest that there is not always a staff member present when a resident is inadvertently brought down to the basement in the elevator.

a) On May 20th, 2015, at 10:46am, the inspector was in the basement and used an access swipe card to activate the button to call for the elevator. Elevator #1 responded to the call. When the elevators doors opened, the inspector saw that the home's Environmental Manager (EM) was in the elevator. The EM indicated to the inspector that he was surprised that the elevator had brought him down to the basement. The EM explained to the inspector that he had entered the elevator from the main floor level, and had pressed the 2R button, as he was intending to go to the 2nd floor service area.

b) On May 20th, 2015, at 10:50am, the inspector was again in the basement and used an access swipe card to activate the button to call for the elevator. Elevator #1 responded to the call. When the elevator doors opened, the inspector saw that a man and a woman were in the elevator, and they expressed confusion as to why they had been brought down to the basement. The inspector went into the elevator with them, and they introduced themselves as family of resident #001. They explained that they were at the home for a care conference for resident #001. They explained they had entered the elevator from

the main floor, and had pressed the 2 button, intending to go up to the second floor.

c) On May 20th, 2015, at 11:11am, the inspector spoke to a cook, #S100, and a dietary aid, #S101, in the kitchen, in the basement. The dietary aid was preparing sandwiches at the time, standing at a work station that allows for visual access of the service elevator area. The inspector asked the staff if they have ever noticed if residents are brought down to the basement in the elevator. They indicated that there are times that residents are brought down to the basement in the elevator, by accident, because someone has called for the elevator from the basement. They specified that it does not happen frequently. Staff #S100 explained that he uses the elevator frequently to go up to the unit serveries. Staff #S100 explained that when he finds a resident in the elevator, in the basement, he makes sure the residents gets back up to the floor that they had intended to go to.

d) On May 21st, 2015, the inspector spoke with a member of resident council, resident # 002, about his/her use of the elevators. The resident confirmed that he/she uses the elevators frequently, and independently. The inspector asked the resident if the elevators had ever brought him/her down to the basement. The resident told the inspector that recently, within the last month, he/she had entered one of the elevators, on the 2nd floor, and then pressed the button to go to the main floor. The resident explained that the elevator did not stop at the main floor, rather, it brought him/her down to the basement. The resident said that it had seemed like no-one had called for the elevator, as he/she didn't see anyone when the elevator doors opened, and no-one got into the elevator with him/her. The resident explained that he/she stayed in the elevator and pressed the button to go back up, to the main floor.

Resident #002 potentially had unsupervised access to the basement at this time.

e) On May 22, 2015, the inspector spoke with resident #003. This resident's name had been provided to the inspector by a Personal Support Worker, who knew that the resident used the elevator independently and would be able to converse with the inspector about it. The inspector asked the resident if the elevator had ever brought him/her down to the basement. The resident indicated that the day before, May 21st, 2015, he/she had ended up in the basement, but he/she had assumed that they had mistakenly pressed the basement button.

The resident explained he/she had entered the elevator from the second floor, and had pressed the button to go down to the main floor. The inspector explained to the resident that as the resident does not have an access swipe card, it would not have been possible for him/her to activate the basement button. The resident said that when the elevator doors opened, he/she could see into the kitchen, and also noticed some large boxes in the hallway and some men working. The resident said that he/she knew right away that they were in the wrong place, and he/she pushed the button to go back up to the main floor. The resident indicated that no one got into the elevator with them. The inspector had been in the basement on multiple occasions on May 21st, and recalled that there had been a number of boxes, in the hallway in front of the elevator, that afternoon, as observed by resident #003.

Further exacerbating the potential risk related to resident access to the basement are the two following issues:

a) Elevator #1 can only be called to the basement with the use of an access swipe card. This is a result of corrective actions taken by the licensee, in response to a Compliance Order issued as a result of the Resident Quality Inspection (RQI #2014_286547_0032, CO #002), related to the elevators. At that time, in December 2014, any person in the basement could call for an elevator, an access swipe card was not needed. The Administrator explained to the inspector that the rational for this change was as follows: by allowing only staff in possession of an access swipe card to call for an elevator, the use of the elevator would be more controlled, and there would be a greater likelihood that a staff member would be present when the elevator descended to the basement.

Residents do not have elevator access swipe cards. If a resident was inadvertently brought down to the basement and left the elevator, the resident would not be able to independently call for the elevator to come back. If there was no staff member present, the resident would have to find another way to leave the basement. The resident-staff communication and response system is not available in the basement. The unlocked and unalarmed stairway and exit doors are all in close proximity to the elevator.

b) The basement doors that lead to the outside of the home are locked from the outside. An access swipe card is required to unlock these doors from the outside. If a resident exited the home through these doors, they would not be able to return back inside the home through these doors. The space

immediately outside of the doors is a receiving area that is below grade and it leads up to the main road used to access the home and the back area of the neighboring hospital. The roadway also goes down a hill and leads to a 4 lane parkway. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

Service Area Office /
Bureau régional de services : Ottawa Service Area Office